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STATE OF MONTANA
LONG-TERM CARE OMBUDSMAN PROGRAM

ANNUAL REPORT
FISCAL YEAR 1984
(October 1, 1983 - September 30, 1984)

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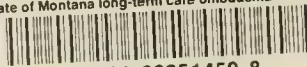
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State Long-Term Care Ombudsman

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INTRODUCTION

The overall purpose of the Long Term Care Ombudsman Program is to work in the area of advocacy with either individual elderly residents of the State's long-term care facilities or all residents of the facilities as a group in order to ensure their health, safety, welfare and rights are protected within the facilities.

Under the federal Older Americans Act (OAA), each state unit on aging is required to establish a Long Term Care Ombudsman Program that performs the following functions as identified in 42 USC 3027, Section 307:

1. Investigate and resolve complaints made by or for older residents living in long-term care facilities that may adversely affect their health, safety, welfare or rights;
2. Monitor the development and implementation of Federal, State and local laws, regulations and policies with respect to long-term care facilities in the State;
3. Provide information to public agencies regarding the problems of older residents of long-term care facilities;
4. Provide training for volunteers and promote the development of citizen organizations to participate in the ombudsman program;
5. Carry out any such duties that the Commissioner of the Administration on Aging deems necessary.

At the present time the specific duties, responsibilities, and limitations of the Long Term Care Ombudsman Program have not been delineated under Montana law.

Funds for the Program come from the following sources:

Title III-B of the OAA.	\$20,000.00
Title III-B State matching funds. . . (approximately)	\$3,500.00
Title IV-C of the OAA	\$50,000.00

(Title IV-C funds pay for a substantial amount of the operation of the Ombudsman Program as well as funding the Elderly Legal Services Developer Program).

The State Long Term Care Ombudsman (LTCO) is the only program staff at the state level. Local services are provided through the State's eleven Area Agencies on Aging (AAA's). They hire and supervise local personnel who provide ombudsman services at the local level. Most of the State's 56 counties have a local individual who is assigned to visit the long-term care facility(s) within their assigned county.

There are approximately 90 nursing homes in the State with about 6,000 beds. The exact number of other long-term care facilities (e.g., personal care homes, retirement/board-ing homes) is difficult to determine at the present time due to changes this year in the licensing categories used by the Department of Health and Environmental Sciences. LTCO's are responsible for advocacy efforts within all these long-term care facilities.

SUMMARY OVERVIEW

During the period covered by this report (Federal fiscal year 1983-84, from October 1, 1983 through September 30, 1984), a number of significant changes and accomplishments occurred within Montana's Long Term Care Ombudsman Program. The following section highlights the most significant events. Further details are provided in subsequent sections of the report.

Program Restructuring

In January 1984, the basic method of service delivery at the State level was changed. The State Long Term Care Ombudsman (LTCO) position was changed from a contracted position to a full-time state employee position. Lenore Taliaferro provided services through the middle of January 1984. Doug Blakley was hired at the end of January 1984. The program was shifted from the Department of Social and Rehabilitative Services (SRS) and administratively attached to the Governor's Office. This was a transitional move designed to provide the program with increased independence. Daily supervision of program activities is provided by the Executive Secretary of the Board of Visitors, Kelly Moore. The Board of Visitors is also administratively attached to the Governor's Office and provides similar advocacy services to residents within the State institutions dealing with developmental disabilities and mental illnesses. Since SRS is the State unit on aging, they still administer the program funds as well as providing supportive services for operating the Ombudsman Program. Legislation to establish a permanent placement and structure for the Ombudsman Program will be introduced in the upcoming legislative session.

Grant Activities

Due to the changes in program structure and personnel, many of the program activities related to reviewing, updating and revising some of the basic components of the program. The most important change occurred in the method of designating local Ombudsman Programs. The designation process is the mechanism used by the State Ombudsman Program to establish an official relationship between the State and local programs and to ensure basic standards for the provision ombudsman services. The State Program and the AAA's worked together to establish more specific guidelines under which local personnel should operate, thus making the designation process a more accurate reflection of what local personnel are doing as ombudsmen. As a result of this process, three designations were developed: Friendly Visitor, Local Long Term Care Ombudsman, and Certified Ombudsman. These designation levels represent a hierarchy of increasing involvement and responsibility. Letters of Understanding have been finalized with eight (8) of the AAA's, and are in the process of being finalized with the other three.

In addition to the designation process, a modification of the reporting and documentation process was instituted to simplify procedures at the local level and provide a data base on complaints that local personnel are resolving through their advocacy efforts at the local level. There is very little information available at the present time to document the kinds of complaints resolved at the local level. The changes are being pre-tested in three AAA's prior to their implementation on a statewide basis.

Another grant objective, to increase the involvement of the private sector in aging services, resulted in activities that had a direct benefit to the designation process. Through a combined effort between the Area XI Agency on Aging, the local Ombudsman, and the State Program, guidelines and protocol between the local program and the long-term care facilities in Missoula are being developed. This process will not only allow both providers and the local program to be actively involved in developing the guidelines, but will assure a mutual level of understanding between the two entities. An additional outcome of the process is the development of the "Certified Ombudsman" designation. This designation will be achieved through a testing process that will ensure a level of proficiency above that currently required of other Ombudsmen. This accomplishment represents a significant advance in program development for ombudsman services, and provides a level of service for other local programs to strive toward.

On-going efforts to publicize the LTCO Program have continued throughout the year through the use of a number of different means. Continued efforts in this area are crucial due to the constant turnover in the intended recipients of the services and the need for those living and working in long-term care facilities to understand the purpose and scope of the program. Community presentations, presentations to professional groups, news releases and articles, interviews, and public service announcements are the major methods utilized by the State Program to educate and familiarize the general public about the program. Site visits to 31 nursing homes and 6 personal care facilities by the State LTCO was another method used to emphasize the existence and responsibilities of the program. Finally, the work of the local LTCO's, through their on-going visits to facilities and their community contacts serves as a vital component in highlighting the program.

Finally, the State Program was directly involved in 77 individual cases involving 227 separate complaints about the care and conditions within long-term care facilities. With the passage of the Montana Elder Abuse Prevention Act (EAPA), there was a significant increase in the number of cases of abuse, neglect and exploitation that the State LTCO was involved in. A joint agreement for handling these

cases was developed by the State LTCO, SRS, DHES, and the Medicaid Fraud Bureau of the Department of Revenue. Under this agreement, the State LTCO was designated as the agency to receive the initial reports of the abuse, etc. that occur within long-term care facilities, and to coordinate investigations into the reports. A total of 43 cases were reported, with a total of 23 cases substantiated. More information on this and other statistics is provided in subsequent sections.

STATISTICAL REVIEW

One of the primary and certainly the most visible functions of the Ombudsman Program is the investigation and resolution of complaints by or on behalf of residents of long-term care facilities. As previously mentioned, there is not currently in place a reporting and documentation system to provide information on the activities of local ombudsman personnel in investigating and resolving complaints that they handle independently. This is a significant gap in the overall picture of the problems that exist within long-term care facilities in Montana, especially since local personnel receive a significant number of complaints that they act upon. A modified system of data collection is currently being pre-tested to evaluate its effectiveness in filling this gap. When refined, the system will be introduced statewide later in the fiscal year.

Several factors have inhibited data collection by local LTCO's in the past. The main problem has been the already large number of duties that local personnel are required to perform in their joint role as Information and Referral Technician and Local Ombudsman. The large number of duties coupled with the relatively low reimbursement most personnel receive make it difficult to require additional demands for extensive, detailed documentation procedures. In many cases, the effort necessary to report problems may exceed that needed to intervene. The new system is striving to balance the need for data with the time available to perform this task.

Thus, all the data reported herein pertains to cases investigated and resolved by the State Program. At the state level, 77 individual cases involving 227 separate complaints were handled. Table 1 shows the annual case and complaint data over the past four years.

TABLE 1: ANNUAL CASE AND COMPLAINT DATA 1980-1984

<u>FFY</u>	80-81	81-82	82-83	83-84
<u>Cases</u>	*	*	106	77
<u>Complaints</u>	64	329	541	227

*No data available.

This is all the annual data that is available. It is difficult to analyze the statistics for trends over this period for several reasons. First, during this period, three different individuals served in the State LTCO position. The basic method of keeping statistics underwent one significant change during this period. While the same basic method

of reporting statistics has remained intact over the past three years, changes in personnel bring different personal styles, approaches, and emphases on the job of data collection and interpretation. This further complicates comparison of annual statistics. A good example of the effects of these differences can be seen in the differences between the 1982-1983 and 1983-1984 statistics, where the number of cases decreased by 29 while the total number of complaints decrease by over 300. Thus, more emphasis is placed here on analyzing the statistics from the current year, while caution is used in comparing them to previously compiled statistics.

Before beginning an analysis of this year's statistics, it is important to put complaint statistics in perspective. One should avoid the tendency to view all complaints as negative occurrences that require intervention of an adversarial nature because a facility is unwilling to correct it. Verified complaints may exist for a number of reasons. Some may result from inappropriate actions by a facility or its staff, others may be due to a number of other factors of which the facility may not be aware or of which they have no control. Some complaints, once brought to the attention of a facility, are resolved in a cooperative manner, others require intervention by regulatory agencies to correct. Also, complaint data reported covers approximately 140 different categories, some of which do not pertain directly to actions taken by facilities (e.g., guardianship problems, financial exploitation by individuals outside a facility, family problems, or problems with governmental programs such as Medicaid or Social Security). Finally, the heading of long-term care facility covers a wide range of service options, from nursing homes to personal care homes to retirement and boarding homes to state institutions. The State office also occasionally becomes involved in complaints from other settings, such as congregate housing settings or hospitals. Thus, generalizations or oversimplifications of the data and the facilities involved should be avoided.

Annual Case Data by Type of Facility

Table 2 lists the number of cases received at the state level by each of the major facility types.

TABLE 2: NUMBERS AND PERCENTAGES OF CASES BY TYPE OF FACILITY

	<u>Number</u>	<u>Percentage</u>
Nursing Homes	65	84
Personal Care/Retirement Homes	9	12
State Institutions	3	4
Other	0	0
TOTAL	77	100

Statistics for personal care homes and retirement/boarding homes are combined here because these licensing categories are unclear at this time due to the changes made at the end of June of this year. At that time, responsibility for licensing personal care homes shifted from the Food and Consumer Safety Bureau of DHES to the Licensing and Certification Bureau of DHES. This is the same bureau that licenses nursing homes and hospitals. Due to financial constraints, the Licensing and Certification Bureau may not begin to issue licenses to facilities under this new category until some time after the start of 1985.

Because of the greater number of nursing homes and the greater number of clients that they serve, one would expect a larger number of cases to pertain to this kind of setting. At the present time, nearly all nursing homes have a local LTCO who visits on a regular basis, while only about half of the personal care facilities have regular visitations. This fact may contribute somewhat to the predominance of cases from nursing home settings. The proportion of cases originating in each of the settings, shown in Table 2 for 1984 is fairly consistent with statistics reported from prior years. Without knowing how referrals to local LTCO's were done previously, or what exact statistical methods were used in previous years, it is difficult at this time to determine if there is any significance to the decrease in cases reported this year over last year.

Complaint Categories

Table 3 shows the ranking and percentages by category of the complaints received at the state level.

TABLE 3: COMPLAINT CATEGORIES BY RANK AND PERCENTAGE

<u>Rank</u>		<u>Percentage</u>
1	Resident Care	38
2	Complaints not against facilities	15.5
3	Resident rights	14
4	Food/nutrition	11.5
5	Administrative	8
6	Building/sanitation/laundry	5
7	Medications	4
8	Physician services	2
9	Financial	2

A breakdown of the exact numbers and the subheadings under each category may be found in Appendix A.

The ranking and percentages for complaint categories are fairly consistent with those of previous years with the exception of the first two categories, "Resident care" and "Complaints not against facilities." While "Resident care"

continued to be the largest category, "Complaints not against facilities" moved from fifth place the last two years to second. The percentages increased by half for both categories also. Both of these changes occurred mainly due to an increase in cases of elder abuse reported to the State LTCO. With the passage of the Elder Abuse Prevention Act (EAPA), all personnel working in long-term care facilities are required by law to report suspected incidents of abuse, neglect or financial exploitation occurring within facilities to the State LTCO. This mandatory reporting requirement resulted in a substantial increase in the number of physical abuse and financial exploitation cases being identified, these complaints being in the "Resident care" and "Complaints not against facilities" categories respectively.

Other individual complaints that in the past have been cited frequently as problem areas within facilities continued to be reported at a high rate. Inadequate levels of staffing and staff training, guardianship issues, fear of retaliation for reporting complaints, inadequate personal hygiene care and general food complaints were the most frequently mentioned concerns.

Finally, some complaints were more specific to a particular type of facility. Inappropriate placement in a facility and inappropriate staff members administering medications to residents were complaints that were problems usually identified as occurring in personal care homes as opposed to other settings.

Elder Abuse

Due to both the newness of the EAPA and the potential severity of this type of complaint, more specific data has been kept on this topic this year. Table 4 shows those cases reported under the EAPA and the outcome of the investigations into the complaint.

TABLE 4: TYPE OF ELDER ABUSE CASES BY OUTCOME

	<u>Abuse*</u>	<u>Neglect</u>	<u>Exploitation</u>	<u>Total</u>
Substantiated	13	2	8	23
Unsubstantiated	10	3	6	19

*Abuse includes cases of physical, verbal, mental and sexual abuse.

All of the substantiated abuse cases involved physical abuse against a resident of a facility. Some of these cases also involved verbal abuse. Most of the cases were substantiated because they were incidents that were observed by another person who could give an eyewitness accounting of the incident. Eleven of the cases involved staff of

the facility abusing a resident, while two were cases of residents abusing other residents. Eleven of the cases occurred in nursing homes, while two occurred in personal care homes. Six of the thirteen substantiated cases were reported by individuals who were not employed by the facility in which they occurred. In all but one of these cases, staff members of the facility had knowledge of the incident but did not report the incident. Failure to report the incident was usually due to a lack of knowledge about the reporting requirement. All facilities have received copies of the EAPA, but many simply post the Act and have not provided training or further information to staff members. Because of the newness of the law, no one to date has been prosecuted for failure to report an incident of suspected abuse. All but two of the unsubstantiated cases were reported by persons who were not employed by a facility.

A profile of substantiated physical abuse cases indicates that the case usually involves an aide either striking an elderly resident or using excessive force to get the resident to comply with orders given by the aide. Facilities usually discharge an aide who has resorted to the use of inappropriate force. While the problem of physical abuse in all these cases is a serious one, none of the residents involved has sustained injuries requiring medical attention or hospitalization, so no criminal prosecution has resulted from physical abuse cases to date.

With the exception of one unsubstantiated case, all of the cases of financial exploitation have involved inappropriate actions by either the family or friends of the resident. Cases are frequently reported by nursing home administrators who become aware of questionable actions. Cases in this area are most often quite complicated ones that require a substantial amount of investigation by the State LTCO, the Elderly Legal Services Developer and local Adult Protective Service Workers. Guardianship and conservatorship issues and family dynamics frequently play a dominant part in these cases. At present, two of the substantiated cases are being pursued by County Attorneys and may lead to prosecution. In other substantiated cases, the result is often the establishment of some sort of protective oversight or a change in the existing arrangements for oversight.

Complaint Resolution

Table 5 presents data on the outcome of investigation into individual complaints.

TABLE 5: PERCENTAGES OF COMPLAINT RESOLUTION BY CATEGORY

Substantiated by strong standard	36%
Substantiated by weak standard	18%
Cannot prove or disprove	30%
Invalid by strong standard	16%

100%

Further explanation and exact figures for each resolution category can be found in Appendix B. These resolution categories are the ones suggested by The Administration on Aging (AOA), and are used so Montana's data can be compared with that from other states. In comparing the outcome of complaint investigations for different facility types, there are virtually no difference in the proportions with which complaints were resolved. Current statistics were also very similar to those figures reported in prior years. With the exception of statistics for elder abuse cases, statistics are not kept that indicated resolution of complaint investigations by complaint areas.

LONG-TERM CARE ISSUES

Programmatic Issues

1. Program development. As previously mentioned, some significant changes in the basic designation system occurred. These changes were designed to provide a more accurate description of the duties and responsibilities of local ombudsman personnel. Input was solicited from all AAA's and local ombudsman personnel during the spring training sessions on a proposed set of guidelines. Each Area was then contacted individually in order to tailor requirements to individual Area needs and circumstances. Thus, when the final Letters of Understanding were finalized with each Area, both the State Program and the AAA's had agreed to a set of expectations and procedures for the provision of local services.

The designation system was expanded to include three designation levels: Friendly Visitor, Local Long Term Care Ombudsman, and Certified Ombudsman. The majority of AAA's (9) have indicated they would use the Local LTCO designation and its guidelines (see Appendix C). The State Program and Area VI, the Area that will be using the Friendly Visitor designation, are in the process of finalizing the set of guidelines for that designation. The State Program and Area XI are currently in the process of developing guidelines, a training manual, and a certification test for the Certified Ombudsman designation.

In response to concerns expressed by local personnel, AAA Directors, and long-term care providers pertaining to the level of training provided to local personnel, several changes in the method of providing training and information will occur in the upcoming grant year. The State LTCO is developing a training and procedures manual that will act as a basic informational resource for all local personnel and will eliminate some of the need to repeat much of the basic programmatic information at all of the training sessions. This will allow the training sessions to deal with a wider range of topics and provide personnel with more diversified information. The State LTCO will also be preparing short quarterly overviews on various topics to provide updated information to local personnel on current topics of importance within the long-term care field.

An effort will also be made next year to explore alternate methods of providing ombudsman services through AAA's. Further program development and improvement in services are closely tied to the amount of funding available to the program. Without resources to help support local efforts, the time and extent of services that can be provided will continue to be effected.

2. Ombudsman legislation. The establishment of the Long Term Care Ombudsman Program in Montana law has been an on-going concern. While the Older American's Act (OAA) spells out the basic requirements that state programs must meet, each individual state has the ability to develop programs that meet their own specific needs and situations. Establishing the authority, scope and structure of the state and local programs has the advantage of both recognizing the programs and setting parameters for their operation. Additionally, some of the federal requirements (e.g., access to facilities and resident records, confidentiality and access to ombudsman records) require the enactment of state legislation.

There have been indications that legislation will be introduced in the upcoming legislation. The Governor, in his address to the 16th Governor's Conference on Aging, stated he would "request legislation to permanently establish the ombudsman program within the Governor's Office." The most important issues that need to be addressed by legislation are how the program will be structured and where within state government it will be placed, whether local programs are supported financially, and what types of facilities and individuals within the facilities will be served by the program. How the program is structured and where it is housed has a direct effect on its independence and its ability to advocate on behalf of all residents within long-term care facilities. In order to continue to have local personnel present in facilities at a level that makes the program effective, a minimum level of funding needs to be provided to AAA's to at least cover travel expenses incurred by local ombudsmen. The only funds presently available for ombudsman services are provided through the OAA. These funds are used to operate the State Program and the Legal Services Developer Program. What little is left over at the end of each fiscal year is distributed to the AAA's, but the amount is minimal and when divided up between 11 AAA's, is negligible. Thus, local ombudsman services are currently being added on to the responsibilities of the Information and Referral Program, and put a strain on the resources of that Program. The issue of who the program serves will be covered in the next section.

The LTCO and ELSD are presently meeting with the staff of the Governor's Office to discuss these and other issues pertaining to Ombudsman Legislation.

3. Expansion of program duties. Both nationally and within Montana, the issue of who ombudsman programs should serve is receiving a lot of consideration. Amendments to the OAA in 1981 increased the scope of ombudsman services to include personal care settings. Recent trends, such as the development of swing beds within hospitals and the

increase of community based long-term care services, have resulted in additional settings that ombudsman services are being asked to monitor or provide assistance. Congregate housing for the elderly is still another setting where assistance has been requested. Given the constant funding levels for state programs over the last six years and the difficulty in securing funds for local programs, it is increasingly difficult for ombudsman services to meet the demands of assisting in new settings, let alone meet the additional demands of monitoring personal care settings. Swing beds are an area that state programs seem to be most inclined to consider adding because of its similarity to nursing home care. Swing beds are designed to provide temporary nursing home care in hospital settings when a nursing home bed is not available locally. It is a model that is primarily used in rural areas. There are currently 23 hospital settings in Montana with a total of 129 licensed swing beds that can provide this kind of care. Additional hospitals are applying to convert some of their beds as swing beds also. Since the individuals in these beds require nursing type services, some can be expected to need ombudsman services. Because most facilities using swing beds are joint hospital-nursing home facilities, the extension of services to this model in Montana would not be as difficult as in other settings, and is recommended by the State LTCO.

Institutional Issues

1. Staffing levels. The issue of the level of staffing within long-term care facilities is a controversial one that can have a pervasive impact on the quantity and quality of care provided to residents of facilities. The issues of quantity of care necessary and its quality can be very subjective. One person's expectations of what is appropriate can vary greatly from the next person's. Thus, determining levels of staffing necessary is no simple task. Further complicating the problem is the ever changing needs of residents, as well as continual turnover in residents themselves. Inadequate levels of staffing place increased pressures on the staff working to meet the demands of a larger number of residents. Combined with other factors that may be present such as low wage levels for aides, inadequate training, high turnover, and the demanding nature of the job, understaffing can result in patient care being done inappropriately, in an untimely manner, or not at all.

Many patient care complaints received by ombudsmen come as a direct or indirect result of inadequate levels of understaffing. The most common are inadequate personal hygiene care for residents, unanswered call lights, inappropriate use of restraints, staff attitudes, and abuse situations. One frequent and telling remark that ombudsmen often hear from people making complaints on behalf of a resident is, "I'm glad that I can come to the facility and make sure that my resident is getting the care that they need. I

wonder what those who don't have someone visiting them do?" Many family members report being in facilities on a frequent basis and giving care to their residents to make sure the resident's needs are being met. Again, overgeneralizations to all facilities is not appropriate. Some facilities staff at higher than required levels to ensure that the residents have all their needs met.

The roots of the problem of understaffing are complex, and based mainly in regulatory and fiscal issues. Facilities have minimum staffing levels that they must meet. These levels are set by both federal and state laws and regulations. Unfortunately, minimum levels can become maximum levels, and may not meet the changing demands of patient needs or of a changing resident population. Many aspects of the system of reimbursement for care cause problems that end up effecting resident care. Budgetary belt-tightening at the state and federal levels continues to put pressure on the reimbursement rates for care. Combined with the ever increasing inflationary spiral of medical costs, facilities are forced to make cuts, and personnel services, being the largest line item in the budget, can receive the largest cuts.

Because of the complexity of the problem, solutions are not easy. Since most people do not have a second facility available locally, they cannot simply take a resident out of a facility and place them in another one if they are not satisfied with the level of care without having to face the prospect of long trips or less frequent visits. Thus, free market principles are not usually an option that has a great impact on facilities. Action needs to be taken on both the systemic and local levels. One method being explored in other states involves financial incentives for facilities providing above average levels of care and imposing intermediate sanctions on facilities for poor quality care. Unannounced inspections of nursing homes is another option under consideration in Montana that could improve the quality of care and monitor staffing issues more closely. Locally, involvement of family and community members in community or resident councils, if they exist, can be an effective way to bring pressure on facilities that have problems.

2. Personal care homes. Personal care homes are a licensing category that has undergone considerable change this year. Residents of these facilities are individuals that need 24 hour supervision and assistance in performing activities of daily living, but do not have the level of medical needs that a resident of a nursing home would. New rules were adopted by DHES in June of this year as a result of changes made in the 1983 legislature that pertained to licensing of personal care homes. The changes were made to meet federal requirements, and provide more specific requirements for home that will ensure the health, safety and welfare of residents. Licensing will be done by the

Licensing and Certification Bureau of DHES, which is also responsible for licensing nursing homes.

Because of a shortage of personnel and funding, the Licensing and Certification Bureau is presently unable to issue licenses to new facilities or to convert the licenses of facilities currently providing personal care services under the old Food and Consumer Services license. DHES is attempting to get approval for additional funds to hire both temporary personnel to cover immediate needs and more permanent help to assist in future licensing demands. This is necessary not only to meet the increased licensing demands, but to ensure the enforcement of existing regulations.

Due to the change-over in licensing responsibilities and the lack of current DHES licenses, ombudsmen are the only group monitoring conditions in personal care homes and responding to complaints about them. While the actual number of facilities (about 20) and residents (about 250) are small compared to nursing homes, the lack of active regulatory oversight leaves residents in potential jeopardy. Ombudsmen interventions cannot always resolve problems. When interventions are unsuccessful, it is very difficult to proceed because of the lack of alternatives for referral.

3. Elder abuse. The basic intent of the EAPA was to provide information on the extent of this problem in Montana. EAPA has met this objective fairly well for abuse occurring in long-term care facilities. Approximately 25% of the substantiated cases of abuse have occurred in long-term care facilities. This high rate of substantiated cases is undoubtedly the result of a higher rate of reporting rather than a higher rate of incidence.

Given the mandatory reporting requirements that all personnel working in facilities have, the penalties for failing to report any suspected incidents of abuse, and the greater visibility of abuse within facilities, abuse occurring in facilities is more likely to be reported. As the statistics indicated, however, nearly half of the substantiated cases that occurred in facilities were reported by individuals who were not employed by the facility. In most of these cases, staff were aware of the abuse but failed to report it to the State LTCO. As with cases occurring in the community, individuals having knowledge of abuse do not report it for a number of reasons: they are reticent to become involved; they give the perpetrator the benefit of the doubt; they do not want to "snitch or gossip"; they feel that the incident is an isolated one and won't happen again; or they do not know where or how to report the abuse.

On-going efforts are necessary to make staff and the general public aware of the problem, its signs and symptoms, and what can be done about it. Specific training of staff on

elder abuse and abuse reporting, as well as ways of dealing with stress that can lead to abuse, need to be provided in facilities. The State LTCO is working on producing training materials during the upcoming grant year to address this need. An additional video similar to the one produced this past grant period is also being contemplated for the upcoming grant period. The recently completed video is a dramatization that deals with general elder abuse issues, especially those occurring in the community.

Revisions of the EAPA are anticipated in the 1985 Legislature. One problem that has come to light is the inability to track staff members that are discharged for abuse. This problem is especially difficult for discharged aides, since they are not licensed like nurses are. Given the difficulty that facilities may experience in finding people to fill aide positions, obtaining a job as an aide is usually easy. The possibility of an aide being discharged for abuse at one facility and going down the road and getting hired at another facility is very real. This is an issue that needs to receive some attention when reviewing information collected by the EAPA.

4. Other legislative issues. During the short period of time the current State LTCO has been in the position, other issues have come up that have an impact on residents of facilities, but have not been addressed in the same depth as the previously mentioned issues. The following listing of issues are ones that will also be addressed in the upcoming legislative session:

- resident rights
- health care containment
- certificate of need for long-term care beds
- unannounced inspections of long-term care facilities

FUTURE ACTIVITIES

This section outlines objectives that the State LTCO will be undertaking as part of the 1984-5 Advocacy Assistance Grant.

1. Assist in the development of legislation for the Ombudsman Program.
2. Develop additional training materials on elder abuse (including possibly another video).
3. Continue efforts to publicize the existence and functions of the Ombudsman Program (including the development of a poster that can be used in facilities).
4. Provide training and technical assistance to local ombudsman programs (including the development of a training and resource manual and quarterly information and resource materials).
5. Continued technical training for the State LTCO.
6. Develop training and educational materials on the subject of resident rights.
7. Monitor the development of state and federal laws, regulations, and policies as they pertain to long-term care facilities.
8. Continue to work on issues pertaining to elder abuse (including investigation of abuse cases and the development of informational and resource materials on elder abuse that can be distributed to facilities).
9. Encourage the development of resident councils in facilities (including developing a resource file on different council models and the effectiveness of these models).
10. Explore alternative methods of providing ombudsman services with AAA's.

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HELENA, MONTANA 59620

ANNUAL STATISTICS

A. RESIDENT CARE (86) 38%

A-1	Inadequate hygiene care	(7)	A-16	Dehydration	
A-2	Bedsore, decubitus ulcers	(2)	A-17	Doctor not called	(1)
A-3	Not dressed	(1)	A-18	Staff attitudes	(6)
A-4	Not turned	(1)	A-19	Staff poorly trained	(7)
A-5	Not walked, exercised	(2)	Lack/poor quality of:		
A-6	Improper restraints	(5)	A-20	Restorative nursing	(2)
A-7	Unanswered help calls	(2)	A-21	Rehabilitation (OT,PT,ST)	(2)
A-8	Inadequate supervision of resident	(3)	A-22	Social Services	
A-9	Kept up too long		A-23	Dental	
A-10	Improper accident procedures	(2)	A-24	Diagnostic	(1)
A-11	Resident falling	(3)	A-25	Activities (leisure, religious)	
A-12	Physical abuse	(18)	A-26	Inadequate care plan	(1)
A-13	Mental abuse	(3)	A-27	Poor medical equipment (wheel-chair, walker, hearing aid, etc.)	(2)
A-14	Verbal abuse	(7)	A-28	clothing in poor condition	(1)
A-15	Neglect (specify)	(6)	A-29	Other (specify)	(1)

B. PHYSICIAN SERVICES (4) 2%

B-1	Schedule of visits	(1)	B-5	Not responsive in emergency	
B-2	Billing		B-6	Does not take Medicare/Medicaid	
B-3	Inaccessible, unresponsive	(1)	B-7	Other (specify)	(1)
B-4	Diagnosis, treatment	(1)			

C. MEDICATIONS (10) 4%

C-1	Not given according to orders	(1)	C-4	Shortage	(1)
C-2	Administered by inappropriate staff	(4)	C-5	Given against resident's will	
C-3	Over-sedation	(4)	C-6	Other (specify)	

D. FINANCIAL (4) 2%

D-1	Billing/accounting wrong, denied		D-6	Questionable charges	(1)
D-2	Access to own money denied		D-7	Misuse of personal funds by facility	(2)
D-3	Not informed of charges	(1)	D-8	Deposits, other money not returned	
D-4	Charged for services not rendered		D-9	other (specify)	
D-5	Charges not approved in advance				

E. FOOD/NUTRITION (26) 11.5%

E-1	Cold	(3)	E-8	No water available	(1)
E-2	Unappetizing, little variety	(6)	E-9	Nutritionally poor	(5)
E-3	Choices		E-10	Religious preference not followed	
E-4	Snacks		E-11	Insufficient amount	(2)
E-5	Not assisted in eating	(1)	E-12	Unsanitary	(1)
E-6	Special diet not followed	(3)	E-13	Time span	
E-7	Preferences not considered	(1)	E-14	Lack of utensils	
			E-15	Other (specify)	(3)

ANNUAL STATISTICS CONT.

F. ADMINISTRATIVE (18) 8%

F-1	Understaffing	(8)	F-8	Bed not held	
F-2	Admissions procedures	(2)	F-9	Room changes/assignment	(1)
F-3	Admission refused due to Medicaid status		F-10	Roommate conflict	
F-4	Discharge plans, procedures	(1)	F-11	Improper use of staff	
F-5	Improper placement	(2)	F-12	Medical transportation	
F-6	Transfer due to Medicaid status	(1)	F-13	Language barrier (incl. sign lang.)	
F-7	Other improper transfer	(2)	F-14	Laundry procedures	(1)
			F-15	Other (specify)	

G. RESIDENT RIGHTS (32) 14%

G-1	Restriction on right to complain		G-14	Denied rights	(2)
G-2	No grievance procedures		G-15	Visiting hours	
G-3	Religious rights restricted		G-16	Mail opened/not delivered	(1)
G-4	Civil liberties, voting restricted		G-17	No phone privacy	(1)
G-5	Social/community activities restricted	(4)	G-18	Not treated with respect, dignity	(1)
G-6	Medicaid discrimination other than admission or transfer	(2)	G-19	Physical abuse by other resident	(1)
G-7	Religious discrimination		G-20	Verbal abuse by other resident	
G-8	Race discrimination		G-21	Use of possessions restricted	
G-9	Sex discrimination		G-22	Kept in facility against will	(2)
G-10	Not informed of condition		G-23	Threats of eviction from facility	(6)
G-11	Not informed of rights, policies		G-24	Fear of retaliation by facility	(6)
G-12	Confidentiality of records		G-25	Personal items lost, stolen, or used by others	(3)
G-13	Disallowed access to own records		G-26	Violation of privacy	(1)
			G-27	Denied sharing room w/spouse	
			G-28	Other (specify)	

H. BUILDING, SANITATION, LAUNDRY (12) 5%

H-1	Cleanliness	(1)	H-9	Bed, bedside equipment	(1)
H-2	Safety factors (exits, fire, railings)	(4)	H-10	Storage space (amount, security)	(1)
H-3	Offensive odors	(1)	H-11	Supplies	
H-4	Appearance		H-12	Heating	(1)
H-5	Pests		H-13	Cooling, ventilation	(1)
H-6	Bathrooms		H-14	Lighting	
H-7	Linens	(1)	H-15	Water temperature	
H-8	Handicap assessability	(1)	H-16	Outside garbage area	
			H-17	Other (specify)	

J. NOT AGAINST FACILITY (OTHER PROBLEMS) (35) 15.5%

J-1	Financial (bad debts, exploitation)	(12)	J-7	Insurance	
J-2	Medicaid not providing services		J-8	Guardianship, conservatorship, power of attorney	(10)
J-3	Medicaid reclassification	(2)	J-9	Family problems	(5)
J-4	Other Medicaid problem except discrimination	(1)	J-10	Wills	
J-5	SSI, Social Security		J-11	Outside social services agency	(4)
J-6	Medicare		J-12	Inappropriate placement	(1)
			J-13	Other (specify)	

APPENDIX B
LONG TERM CARE OMBUDSMAN COMPLAINT SURVEY 4TH QUARTER 7/1 TO 9/30/84
SENIORS' OFFICE OF LEGAL AND OMBUDSMAN SERVICES (SOLOS)

A. CASES

	<u>SNF/ICF</u>	<u>PC</u>	<u>Rm/Rtr</u>	<u>State Instit.</u>	<u>Other</u>	<u>TOTAL</u>	<u>CUMULATIVE</u>
1. Number of Cases (TOTAL)	28	6		1		35	
2. Number of Cases Carried Over.	6	2				8	
3. Number of Cases Opened.....	22	4		1		27	77
4. Number of Cases Resolved....	4			1		5	
5. Number of Cases Closed.....	24	4				28	
6. Number of Cases Pending.....							

B. COMPLAINTS

1. Number of Complaints (TOTAL).	55	12		2		69	227
2. Number of Complaints Verified:							
a. Strong Standard.....	26	5		1		32	83
b. Weak Standard.....	13					14	41
c. Cannot prove or disprove.	9	2				11	68
d. Invalid by strong standard	7	5				12	35

DEFINITIONS:

CASE: Contact by a complainant, facility, group, etc. about concern(s) that result in an investigation.

COMPLAINT: Separate area or issue identified by complainant as problematic (e.g. food, patient care, rights, etc.).

OPENED: Cases initiated within this reporting period.

CARRIED OVER: Cases from last reporting period that required further work this period.

RESOLVED: Corrected or in the process of being corrected.

CLOSED: Resolution accomplished and parties satisfied, including Ombudsman.

PENDING: Cases that were not resolved this period and will be carried over next period for continued investigation.

VERIFICATION:

(See above [B], a, b, c, d)

- Substantiated by documentation, eye witness reports, deficiency citing by DHES, internal corrective actions taken, etc.
- No hard documentation but investigation partially substantiates complaint.
- Investigation did not provide sufficient evidence to reliably determine the validity or invalidity of complaint.
- Investigation finds evidence contradictory to reported complaint and substantiated by investigating authorities.

SNF - Skilled Care Facility licensed by the Licensing and Certification Bureau of the Dept. of Health and Environmental Sciences.

ICF - Intermediate Care Facility licensed by the Licensing and Certification Bureau of the Dept of Health and Environmental Sciences.

PC - Personal Care Facility licensed by the Licensing and Certification Bureau of the Dept. of Health and Environmental Sc

RM/RTR - Residential Care Facility licensed by Food & Consumer Safety Bureau, Dept of Health and Environmental Sciences.

STATE INST. - Facilities under the jurisdiction of the Department of Institutions.

OTHER - Adult Foster Care, Unlicensed Facility, or Complaints related to family, legal, or local, state or federal programs

APPENDIX C

Mission Statement

The primary purpose of ombudsman services is to help patients or residents who are over 60 and who reside in long-term care facilities (skilled or intermediate nursing homes, personal care homes, retirement homes) to assert their rights and express their grievances on issues pertaining to their health, safety, welfare and rights within long-term care facilities.

Local Long Term Care Ombudsmen provide residents and those concerned about them with an access point to meet this purpose. They serve as a resource in resolving concerns and complaints about quality of care and quality of life issues through the use of a broad spectrum of strategies that include educating residents about their rights and responsibilities within a facility, promoting self advocacy, advocating on behalf of a resident, and referring complaints for intervention by state agencies. As an integral part of ombudsman services, local LTCO's seek to provide an objective review of complaints. If the complaints are substantiated, they assist in the complaint resolution process and conduct follow-up on implemented strategies.

The following is a set of guidelines that local personnel who are designated as Long Term Care Ombudsmen should use in meeting the mission statement of the program.

1. Visit your assigned facility(s) a minimum of once per month.

2. Submit a report on your visit(s) to the facilities to your AAA Director so they can forward it to the State offices.

3. Familiarize yourself with the facilities you visit. You should have a working knowledge of the following areas: key staff within the facility and what they are responsible for; the ownership of the facility (i.e., is it locally owned, owned by a chain, etc.); is there a resident council or community council, when does it meet, who runs it, how effective is it; the facility's grievance procedures and their effectiveness; the kinds of different daily activities through which you can meet other residents.

4. Familiarize the personnel in the facility with how the LTCO program functions, and how you as a local LTCO fit in.

5. Establish a relationship with the administrator of the facility that will continue to allow you access to local facilities. While there has not been any significant problems with access to this point, LTCO's do not have any legal mandate that allows them to function within facilities in Montana. Thus, the relationship with the administrator is crucial. LTCO's should find out what kind of procedures the administrator wants to establish, if any, for the LTCO entering the facility for visits. A minimum quarterly visit

should be held with the administrator to maintain the relationship that LTCO's have established. Any problems with access should be reported to the state LTCO immediately.

6. In those facilities that have resident councils, LTCO's should try to attend a council meeting at least semi annually, if the administrator will allow participation. This allows the LTCO the opportunity to work with an established entity within the facility that has similar goals and increases the LTCO's knowledge of potential problems within the facility as well as residents within the facility that are working to resolve them.

7. LTCO's should use the following hierarchical guidelines when involved in the reporting, investigation, verification, and resolution of complaints:

a. LTCO's need to take some action on all complaints reported to them, be it to promote self advocacy, intervene personally, or to refer.

b. The major complaint area that local LTCO's should operate in pertains to problems arising in the course of daily living within facilities (e.g., food complaints, lost or missing personal articles, staff attentiveness, problems relating to use of personal spending money, or rights issues). Other problems may be appropriate for referrals commonly used as an I&R technician. A list of specific areas that should be referred to the state office first is provided below. Area Directors may have further requirements that should be adhered to.

c. For those complaints that LTCO's do get involved in, the first step that should be taken is to promote self advocacy by the complainant, if at all possible. This increases self determination and allows the complainant to develop skills to resolve their own complaints in the future. Strategies to use in approaching an administrator and background information on rights should be provided.

d. If the complainant is unable to resolve the problem through self advocacy, the LTCO may intervene with the resident or on their behalf, at the request of the resident.

e. For those complaints that the LTCO has had limited experience in handling in the past or with which they feel that they need assistance, they should consult with their area director or the state LTCO.

f. For those complaints that require intervention by other state agencies or require the intervention of the state LTCO, a referral should be made, using established Area procedures. In making referrals to the state LTCO, have as much detailed information available as possible in order to facilitate the investigation process.

8. Confidentiality in all phases of the complaint process should be maintained. The identity of the complainant and information pertaining to the investigation should not be disclosed to anyone other than the LTCO's immediate supervisor and the state LTCO. Any records generated by

the LTCO should be secured in a safe place or destroyed on completion of the investigation.

9. Because of their accessibility to facilities, local LTCO's are in a unique position to assist in following up on complaints that have been resolved, to ensure that the resolution steps are being implemented at the local level.

The following limitations should be observed by local LTCO's:

1. Local LTCO's should not give statements to the media on any matters pertaining to investigations they have information about.

2. Local LTCO's should not initiate any investigations into any allegations of elder abuse, neglect or exploitation that they come into contact with. Any information pertaining to elder abuse should be immediately reported to the state LTCO, if it occurs within a long term care facility, or to their local Adult Social Worker if it occurs within the community. Under the new Elder Abuse Prevention Act, these two entities have responsibility for initiating procedures for the investigation into allegations.

3. Any complaints that pertain to legal matters should be referred to the Elderly Legal Services Developer in the Seniors' Office in Helena.

4. Any complaints that pertain to medications or eminent medical danger situations (e.g., infected bedsores) should be immediately brought to the attention of the administrator or director of nursing of the facility and reported to the Area Director and state LTCO.

The state LTCO is available to answer any questions pertaining to ombudsman issues, and can be contacted by calling the toll free number, 800-332-2272.

